

STATE OF HAWAII

METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES FOR LONG-TERM CARE FACILITIES

I. DEFINITIONS

When used in this Plan, the following terms shall have the indicated meanings:

- A. "Acuity Level A" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively lower than Acuity Level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF.
- B. "Acuity Level B" means that the Department has applied its standards of medical necessity and determined that the Resident requires the level of medical care and special services that are appropriately obtained from an ICF/MR.
- C. "Acuity Level C" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively higher than Acuity Level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.
- D. "Acuity Level D" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care that is relatively higher than Acuity Level C but less than acute.
- E. "Acuity Ratio" means the estimated average Level A direct nursing costs divided by the estimated average Level C direct nursing costs, as determined by the Department. For the FY 98 Rebasing, the Department has determined the ratio to be 1.00:0.8012.
- F. "Adjusted PPS Rate" means the Basic PPS Rate and any adjustments to that rate that are applicable to a particular Provider. A

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formula to determine the Adjusted PPS Rate is defined in Section VIII.E.2.

- G. "Ancillaries Payment" means a per diem payment outside of the Basic PPS Rate to reimburse certain Providers for ancillary services that they provide to Residents. The payment is available only to selected Providers that are incapable of billing Medicaid on an itemized fee for services basis at this time. The payment is not an adjustment to the Basic PPS Rate.
- H. "Audit Adjustment Factor" means a reduction to the costs reported in a cost report that has not been finally settled by the Department to reflect the average amount of costs that the Department has historically disallowed for facilities statewide as part of the final settlement process.
- I. "Basic PPS Rate" means the sum of the applicable per diem amounts for the direct nursing, capital, and G&A components for each Provider and for each level of care that the Provider is certified to provide, as calculated pursuant to the methodology defined in this Plan. It does not include the various adjustments or increases to that basic per diem rate defined in this Plan.
- J. "Base Year" means the state fiscal year chosen to identify the Provider-specific cost reports that are used to calculate the Basic PPS Rates.
- K. "Base Year Cost Report" means the cost report of a Provider that covers the reporting period that ends during the Base Year.
- L. "Capital Component Reduction Factor" means a fraction with the capital cost per diem projected by a new Provider to obtain its initial PPS Rates as the numerator and the total projected capital, direct nursing and G&A per diem costs as the denominator.
- M. "Capital Incentive Adjustment" means an increase to a Provider's Basic PPS Rates that is calculated as follows:
 - 1. If the capital per diem cost component of the Provider's Basic PPS Rate is in the lowest quartile of its peer group, then the incentive payment shall be 35% of the difference

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between the median per diem for the peer group and the Provider's capital per diem cost component.

2. If the capital per diem cost component of the Provider's Basic PPS Rate is in the second lowest quartile of its peer group, then the incentive payment shall be 25% of the difference between the median per diem for the peer group and the Provider's capital per diem cost component.
 3. Notwithstanding the foregoing, the Capital Incentive Adjustment shall not increase a Provider's capital cost component above the capital component ceiling for the applicable acuity level in the Provider's peer group.
- N. "Department" means the Department of Human Services of the State of Hawaii, which is the single state agency responsible for administering the Medicaid program.
- O. "FY 98 Rebasing" means the Rebasing that used the cost reports for fiscal years that ended during the state fiscal year ending June 30, 1995. The Basic PPS Rates that resulted from the FY 98 Rebasing are effective July 1, 1997.
- P. "G&A" means general and administrative.
- Q. "G&A Incentive Adjustment" means an increase to a Provider's Basic PPS Rates that is calculated as follows:
1. If the G&A per diem cost component of the Provider's Basic PPS Rate is in the lowest quartile of its peer group, then the incentive payment shall be 35% of the difference between the median per diem for the peer group and the Provider's G&A per diem cost component.
 2. If the G&A per diem cost component of the Provider's Basic PPS Rate is in the second lowest quartile of its peer group, then the incentive payment shall be 25% of the difference between the median per diem for the peer group and the Provider's G&A per diem cost component.
 3. Notwithstanding the foregoing, the G&A Incentive Adjustment shall not increase a Provider's G&A cost component above the

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G&A component ceiling for the applicable acuity level in the Provider's peer group.

- R. "GET Adjustment" means the adjustment to the Basic PPS Rate of a proprietary Provider to reimburse it for gross excise taxes paid to the State of Hawaii. The GET Adjustment shall be 1.04167; provided, however, that if the gross excise tax rate is increased or decreased, then the GET Adjustment shall be revised accordingly.
- S. "Grandfathered Capital Component" means the capital component of the Basic PPS Rates that a New Provider or a Provider with New Beds was receiving immediately prior to the FY 98 Rebasing.
- T. "Grandfathered Direct Nursing and G&A Adjustment" means an increase to an eligible Provider's Basic PPS Rates calculated as follows: first, the Department shall determine the Provider's combined direct nursing and G&A components (including all incentives) as calculated in the FY 98 Rebasing; second, the Department shall determine the combined direct nursing and G&A component in the Total PPS Rates that the Provider was receiving prior to the FY 98 Rebasing for its Old Beds; third, the Department shall increase that second amount by one-half of the Inflation Adjustment for FY 98; and finally, if the difference between the second amount and the first amount is a positive number, that number shall be multiplied by the ratio of the Provider's Old Beds to its total beds. The product shall be the per diem increase to the Provider's Basic PPS Rates.
- U. "Grandfathered PPS Rate" means the Total PPS Rate that a Provider was receiving prior to the FY 98 Rebasing; provided, however, that the NF Adjustment, the OBRA 87 Adjustment, and any rate reconsideration adjustments shall not be included in the Grandfathered PPS Rate for the purpose of the FY 98 Rebasing.
- V. "G & A Small Facility Adjustment" means an adjustment to a small freestanding Nursing Facility's basic PPS rates.

To qualify for this adjustment, the freestanding Nursing Facility must:

1. Have 50 beds or less and

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2. Have a base year facility specific G & A cost per day in excess of their facility specific G & A cost component ceiling.

To calculate the adjustment, the G & A cost component of the provider's basic PPS rate calculation is recomputed as follows:

1. A cost differential in the average base year G & A cost per day, inflated to the PPS rate year, is computed between:
 - a. F/S NFs with "50 beds or less" and
 - b. F/S NFs with "more than 50 beds but less than 125".
 2. The provider's G & A cost component ceiling is increased by the computed cost differential described above.
 3. The facility specific G & A cost per day is compared with the revised ceiling to determine the revised allowable G & A cost component of the provider's basic PPS rate.
 4. The increase in the G & A portion of the provider's PPS rate as a result of the above calculations represents the adjustment.
- W. "ICF" means intermediate care facility.
- X. "ICF/MR" means intermediate care facility for the mentally retarded. The term also refers to a level of certification of a Provider by Medicaid.
- Y. "Inflation Adjustment" means the estimate of inflation in the costs of providing Nursing Facility services for a particular period as estimated in the DRI McGraw-Hill Health Care Costs: National Forecast Tables, HCFA Nursing Home Without Capital Market Basket, or its successor.
- Z. "Insufficient Experience" means that a Provider's Base Year cost report indicates that the Provider delivered less than 100 days of care at a particular Acuity Level in the Base Year.

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- AA. "Level A Rate" means the PPS Rate for care delivered by a Provider to an Acuity Level A Resident in a Nursing Facility.
- BB. "Level B Rate" means the PPS Rate for care delivered by a Provider to an Acuity Level B Resident in an ICF/MR.
- CC. "Level C Rate" means the PPS Rate for care delivered by a Provider to an Acuity Level C Resident in a Nursing Facility.
- DD. "Level D Rate" means the PPS rate for care delivered by a Provider to an Acuity Level D Resident in a Nursing Facility.
- EE. "Maintenance Therapy" means therapy provided by nursing staff or others whose purpose is not restorative or rehabilitative, but rather to prevent the decline in the physical capabilities of Patients. Maintenance Therapy does not include physical therapy services that are reimbursed outside of the Basic PPS Rates.
- FF. "Medicaid" means the program to provide certain medical services to eligible individuals as defined generally in Title XIX of the Social Security Act, as amended from time to time.
- GG. "New Beds" means beds of a Provider that were placed into service after the implementation of the Hawaii Medicaid program's initial prospective payment system.
- HH. "New Provider" means a Provider that began operations after the implementation of the Hawaii Medicaid program's initial prospective payment system.
- II. "NF Tax Adjustment" means the adjustment to the Basic PPS Rate to a Provider to reimburse it Medicaid's share of the taxes paid under Act 315, Hawaii Laws of 1993. The NF Tax Adjustment was paid under a prior version of this Plan during the period beginning July 1, 1993, and ending June 30, 1997.
- JJ. "Nursing Facility" or "NF" means a Provider that is certified as a nursing facility under Medicaid.
- KK. "OBRA 87" means the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, and its interpretive guidelines and implementing regulations.

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- LL. "OBRA 87 Adjustment" means the adjustment to the Basic PPS Rate to reimburse a Provider for the incremental costs of complying with OBRA 87. The OBRA 87 Adjustment was paid under a prior version of this Plan during the period beginning July 1, 1993, and ending June 30, 1997.
- MM. "Old Beds" means the beds of a Provider that were placed in service prior to the implementation of the Hawaii Medicaid program's initial prospective payment system.
- NN. "Patient" means an individual who receives medical care from a Provider, and includes both Residents and persons whose care is paid for by sources other than Medicaid.
- OO. "Plan" means this document, which defines the methods and standards whereby the Hawaii Medicaid program sets the rates that it pays to Providers for services that they provide to Residents.
- PP. "PPS" means the prospective payment system defined in this Plan.
- QQ. "Provider" means a facility that is or becomes certified as qualified and contracts with the Department to provide institutional long-term care services to Residents.
- RR. "Rebasing" means calculating the Basic PPS Rates by reference to a new Base Year and new Base Year Cost Reports. "Rebased" Basic PPS Rates are the end product of a Rebasing.
- SS. "Resident" means the individual who is eligible for benefits under Medicaid and receives long-term care benefits from or through a Provider.
- TT. "ROE Adjustment" means the adjustment to the Basic PPS Rate to a proprietary Provider to reimburse it for return on equity, as computed and paid according to this Plan.
- UU. "SNF" means skilled nursing facility.
- VV. "Substitute Direct Nursing Component" means adjusting the direct nursing care component used to obtain a Basic PPS Rate for an acuity level as follows:

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1. increasing the facility-specific Level A direct nursing component by dividing that component by the Acuity Ratio; or
 2. decreasing the facility-specific Level C direct nursing component by multiplying it times the Acuity Ratio.
 3. In calculating the Substitute Direct Nursing Component, the Acuity Ratio shall be applied to the Provider's direct nursing component prior to the application of the direct nursing component ceiling.
- WW. "Total PPS Rate" means the Basic PPS Rate plus all applicable adjustments, additions or increases to that rate that are defined and authorized in this Plan.
- XX. "Upper Limit" means the limit on aggregate payments to Providers imposed by 42 C.F.R. § 447.272.

II. GENERAL PROVISIONS

A. Purpose

The purpose of this Plan is to establish a prospective payment reimbursement system for long-term care facilities that complies with the Social Security Act and the Code of Federal Regulations. The Plan describes principles to be followed by Providers in making financial reports and describes procedures to be followed by the Department in setting rates, making adjustments to those rates, and auditing cost reports.

B. Objective

Pursuant to the requirements of the Omnibus Budget Reconciliation Act of 1980, the objective of this Plan is to establish rates for long-term care facilities that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated Providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

C. Reimbursement Principles

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1. Except as noted herein, the Hawaii Medicaid program shall reimburse Providers based on the number of days of care that the Provider delivers to the Resident, the acuity level that is medically necessary for each day of care, and the Provider's PPS Rate. The Provider shall receive payment at the Level A Rate for residents who require care at Acuity Level A, at the Level B Rate for Residents who require care at Acuity Level B, at the Level C Rate for Residents who require care at Acuity Level C, and at the Level D Rate for Residents who require care at Acuity Level D. Any payments made by Residents (or other third parties on behalf of Residents) shall be deducted from the reimbursement paid to Providers.
2. Except as noted herein, the Medicaid program shall pay for institutional long-term care services through the use of a facility-specific, prospective per diem rate.
3. The Basic PPS Rate shall be developed based on each Provider's historical costs (as reflected in its Base Year Cost Report) and allocated to three components, which are subject to component cost ceilings.
4. A proprietary Provider shall receive the GET and ROE Adjustments to its Basic PPS Rate to account for gross excise taxes and return on equity.
5. Rates for acute care facilities with federally designated swing beds shall be established according to 42 C.F.R. §447.280.
6. Changes in ownership, management, control, operation, and leasehold interests which result in increased costs for the successor owner, management, or leaseholder, shall be recognized for reimbursement purposes only to the following extent: Pursuant to the provisions of Section 9509 (a) (4) (C) of P.L. 99-272, the valuation of capital assets shall not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of:

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- a) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary of Health and Human Services) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change in ownership during the fiscal year; or
 - b) one half of percentage increase (as measured over the same period of time) in the Consumer Price Index for all Urban Consumer (United States city average).
- 7. The Department shall pay the Providers separately for ancillary services based on a fee schedule or through an Ancillaries Payment.
 - 8. Nursing Facilities that have G&A or capital costs below the median for their peer group are rewarded with an incentive payment. A formula to determine the G & A Incentive Adjustment is defined in Section I. Q. A formula to determine the Capital Incentive Adjustment is defined in Section I. M.
 - 9. The Department may contract with Providers to provide Acuity Level D care to selected Residents.

D. Access to Data

Members of the public may obtain the data and methodology used in establishing payment rates for Providers by following the procedures defined in the Uniform Information Practices Act, Haw. Rev. Stat. chapter 92F, (A copy of Hawaii Revised Statutes 92F is appended to Plan as Exhibit 92F).

III. SERVICES INCLUDED IN THE BASIC PPS RATE

- A. The reasonable and necessary costs of providing the following items and services shall be included in the Basic PPS Rate and shall not be separately reimbursable unless specifically excluded under Section III.B.

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